The Purpose School

1 Church St
Stoneham, MA 02180
Fax: 781-438-0238

AUTHORIZATION FOR MEDICATION

I hereby authorize THE PURPOSE SCHOOL STAFF to administer the following medication to my child. All staff are trained in the "5 rights of medicine".

Staff can never administer the first dose of a new medicine due to concerns of possible reaction to the medication.

Name of Child:_____

Medication:_____

Please select one: ☐ Prescription or ☐ Non-Prescription

Directions:_____

_____

Please note that any Non-Prescription medication must have a written doctor's note or the Doctor's signature on this form. We cannot administer medicine after the expiration date has been reached. Please bring in two (2) Epi Pens in their original box.

Dosage:_____

Time:_____

Start Date:_____ Ending Date:_____

Parent's Signature:_____

Doctor's Signature:_____
(Required for all non-prescription medications.)

DATES	DOSAGE	TIME	STAFF NAME